United States Court of Appeals

for the Second Circuit

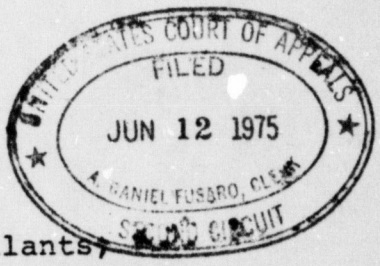
APPELLEE'S BRIEF

75-6038

To be argued by
JOHN M. DUFUR

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

Docket No. 75-6038



MABEL M. CASE, d/b/a CASE NURSING HOME, and
LOUISE UNGARO, d/b/a PHILLIPS NURSING HOME,

Plaintiffs-Appellants,

- against -

CASPAR WEINBERGER, as Secretary of the United States Department of Health Education & Welfare; BERNICE L. BERNSTEIN, as Regional Director for Region II of the United States Department of Health, Education & Welfare; ALAN J. SAPERSTEIN, Director, Office of Long Term Care, Region II, HEW,

Defendants-Appellants-
Appellees,

and

ABE LAVINE, Commissioner of the New York State Department of Social Services; and JOHN LASCARIS, Commissioner of the Onondaga County Department of Social Services,

Defendants-Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF
NEW YORK

BRIEF FOR DEFENDANT-APPELLEE LAVINE

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CASES CITED

STATUTE INVOLVED

The statute involved herein is Public Law 92-603 § 246, a copy of which is attached hereto as Appendix "A"

REGULATION INVOLVED

The federal regulation involved herein is 45 CFR § 249.33(a), a copy of which is attached hereto as Appendix "B".

UNITED STATES COURT OF APPEALS
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APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF NEW YORK

BRIEF FOR DEFENDANT-APPELLEE LAVINE

PRELIMINARY STATEMENT

This is an appeal by plaintiffs Mabel M. Case owner and operator of the Case Nursing Home and Louise Ungaro owner

and operator of the Phillips Nursing Home, and a further appeal by defendants Caspar Weinberger, Bernice L. Bernstein and Alan J. Saperstein of the United States Department of Health, Education and Welfare (federal defendants) from an order of Honorable Edmund Port, dated May 9, 1975, which directed defendant Weinberger to grant plaintiffs hearings within 90 days after requested, denied plaintiffs' request for convocation of a three judge court and denied all other relief demanded by the plaintiffs in the complaint.

ISSUE PRESENTED

Did the District Court err in denying plaintiffs' request for preliminary and permanent injunctive relief prohibiting defendants from decertifying plaintiffs from the Medicaid program, Title XIX, Social Security Act (42 U. S. C. § 1396 et seq.) as a provider of care, and, moreover, in directing that plaintiffs be given a full adversary hearing after decertification from the Medicaid program?

DECISION BELOW

The District Court, after trial on May 7 and May 8, 1975, dictated its decision on the record, denying plaintiffs' request for injunctive relief prohibiting their decertification from the Medicaid program. An order was entered on May 12, 1975.

STATEMENT OF THE CASE

Appellant Mabel M. Case is the owner and operator of the Case Nursing Home located in Syracuse, New York. Appellant Louise Ungaro is the owner and operator of the Phillips Nursing Home also located in Syracuse, New York. Appellants challenge the decertification of their nursing homes from the Medicaid program, Title XIX, Social Security Act, 42 U. S. C. § 1396 et seq.

Defendant Lavine was the Commissioner of the New York State Department of Social Services. He was replaced on June 2, 1975 by Stephen Berger who is now the Acting Commissioner of Social Services. As head of the New York State Department of Social Services, the Commissioner is responsible for overseeing compliance by the State with the federal Medicaid program.

Defendant Lascaris is the Onondaga County Commissioner of Social Services and as such is responsible for the operation of the Medicaid program at the County level. These duties include the placement of Medicaid patients in properly certified nursing homes.

On July 1, 1973, Public Law 92-603, § 246, [42 U. S. C. § 1395x(j)(13), § 1396a(a)(28)] eliminated the State's authority to grant waivers of Life Safety Code deficiencies to nursing homes participating in the Medicaid program. That power now rests with the Secretary of Health, Education and Welfare (HEW).

Pursuant to this change in federal law and the regulations promulgated by HEW implementing the amendment [45 CFR 249.33(a)], the New York State Health Department made recommendations to HEW based on surveys of appellants' homes regarding waiver of Life Safety Code deficiencies found therein. HEW held a review at which appellants and their representatives were present, and subsequently determined not to grant waivers, thus decertifying appellants' homes from the Medicaid program. Pursuant to the federal regulations, HEW notified Health of its decision. Health notified defendant Lavine who advised the homes of the effect of the decision, i.e., termination of federal and state reimbursement and the transfer of the patients to properly certified facilities.

This action was commenced by filing the complaint on April 18, 1975 in the United States District Court for the Northern District of New York. In addition, an order to show cause was signed returnable April 28, 1975 seeking a three-judge court and also seeking preliminary and permanent injunctive relief prohibiting appellants' homes from being decertified from the Medicaid program. By order dated April 28, 1975 Judge Port issued a stay prohibiting the termination of reimbursement and the transfer of the patients in appellants' homes, pending the hearing on the preliminary and permanent injunction on May 7, 1975.

On May 8, 1975 after hearing testimony of one witness and oral argument Judge Port dictated his decision on the record

denying appellants all the relief sought, except directing that appellants be given, if requested, post termination hearings by HEW. The Court entered an order on May 12, 1975, as noted supra. That order also extended the stay issued on April 28, 1975 for 10 days in order to allow the parties to seek relief from this Court pending appeal

By order to show cause signed May 19, 1975, appellants sought a stay from this Court pending the hearing and determination of their appeal. Argument thereon was heard on May 27, 1975, at which time the motion was denied and the appeal herein was directed to be expedited. Argument has been scheduled for June 18, 1975.

ARGUMENT

THE COURT BELOW PROPERLY DENIED PRELIMINARY AND INJUNCTIVE RELIEF.

The test for determining whether to grant injunctive relief is made up of two elements (1) substantial likelihood of success and (2) the possibility of irreparable injury to the applicant flowing from denial. Charlie's Girls, Inc. v. Revlon, Inc., 49 F. 2d 953 (2d Cir., 1973); Gulf Western Industries, Inc. v. Great Atlantic & Pacific Tea Co., 476 F. 2d 687 (2d Cir., 1973). Neither of these elements, it is submitted, are present here.

With the enactment of Public Law 92-603 § 246 [42 U. S. C. § 1395(x)(j)(13), § 1396(a)(28)] effective July 1, 1973 the State's authority to grant waivers of Life Safety Code deficiencies was eliminated and that power was vested by Congress in the Secretary of HEW. HEW implemented this statutory amendment by regulations published on January 17, 1974 [45 CFR § 249.33(a)].

Thereafter, HEW decertified plaintiffs' nursing homes after affording them a review. It is this review procedure which is at the heart of this litigation. Pursuant to the federal regulatory scheme defendant Lavine was required to issue directives to the local social services district informing it of the termination of reimbursement and the requirement that Medicaid patients be transferred to properly certified facilities.

(See Saperstein affidavit, sworn to May 5, 1975.)

From the foregoing, it is obvious that nothing actionable has been alleged against the defendant. Nor, in fact, was anything proved in this regard. Accordingly, as against defendant Lavine there has been no showing of the likelihood of success on the merits.

The decision of this Court in Maxwell v. Wyman, 458 F. 2d 1146 (2d Cir., 1972) involved the law as it existed prior to July 1, 1973, as noted above, when the State was the sole determiner of waiver of Life Safety Code deficiencies. In that decision this Court found that some review procedure was necessary when a nursing home was decertified from the Medicaid program. The decision, however, implicitly left open the question of the timing of such review and explicitly declined to decide whether due process required a review.

In his decision in the instant case, Judge Port reached an issue not reached in Maxwell and found that if a pre-termination hearing comporting with due process was necessary, the review given plaintiffs by HEW comported therewith. Having decided this issue, Judge Port need have gone no further.

As this Court has held in the past, Berrigan v. Norton, 451 F. 2d 790 (2d Cir., 1971), the granting of an injunction rests in the discretion of the Court. It is submitted that the Court below did not abuse its discretion in denying plaintiffs injunctive relief. However, it is submitted that by requiring

a post termination review the trial court decided an issue not raised by the pleadings and granted relief not sought by any of the parties.

CONCLUSION

PLAINTIFFS' APPEAL SHOULD BE DISMISSED.

Dated: June 12, 1975

Respectfully submitted,

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with guidelines established by the Secretary) that a lump-sum payment would be more economical than the anticipated period of rental payments. Such experiments may also provide for incentives to beneficiaries (including waiver of the 20 percent coinsurance amount applicable under section 1833 of the Social Security Act) to purchase used equipment whenever the purchase price is at least 25 percent less than the reasonable charge for new equipment.

79 Stat. 302.
42 USC 1395l.

(c) The Secretary is authorized, at such time as he deems appropriate, to implement on a nationwide basis any such reimbursement procedures which he finds to be workable, desirable and economical and which are consistent with the purposes of this section.

(d) Section 1833(f) of the Social Security Act is amended— 81 Stat. 850.

(1) by striking out "with respect to purchases of inexpensive equipment (as determined by the Secretary)" and inserting in lieu thereof "(A)", and

(2) by inserting before the period at the end thereof the following: ", and (B) with respect to purchases of used equipment the Secretary is authorized to waive the 20 percent coinsurance amount applicable under subsection (a) whenever the purchase price of such equipment is at least 25 percent less than the reasonable charge for comparable new equipment."

(3) by inserting "(1)" after "(f)" and by adding after paragraph (1) the following new paragraph:

"(2) In the case of rental of durable medical equipment, the Secretary may, pursuant to agreements made with suppliers of such equipment, establish any reimbursement procedures (including payment on a lump-sum basis in lieu of prolonged rental payments) which he finds to be equitable, economical, and feasible."

UNIFORM STANDARDS FOR SKILLED NURSING FACILITIES UNDER MEDICARE AND MEDICAID

42 USC 1396a.

SEC. 246. (a) Section 1902(a)(28) of the Social Security Act is amended to read as follows:

"(28) provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1861(j), except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases and tuberculosis shall not apply for purposes of this title;"

(b) Section 1861(j) of such Act, as amended by section 234(d) of this Act, is further amended— Ante, p. 412.

(1) by striking out "and" at the end of paragraph (10);

(2) by redesignating paragraph (11) as paragraph (15);

(3) by inserting after paragraph (10) the following new paragraphs:

"(11) supplies full and complete information to the Secretary or his delegate as to the identity (A) of each person who has any direct or indirect ownership interest of 10 per centum or more in such skilled nursing facility or who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by such skilled nursing facility or any of the property or assets of such skilled nursing facility, (B) in case a skilled nursing facility is organized as a corporation, of each officer and director of the corporation, and (C) in case a skilled nursing facility is organized as a partnership, of each partner; and promptly reports any changes which would affect the current accuracy of the information so required to be supplied;

"(12) cooperates in an effective program which provides for a regular program of independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including medical evaluation of each patient's need for skilled nursing facility care);

"(13) meets such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to nursing homes; except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home, but only if such waiver will not adversely affect the health and safety of the patients; except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing facilities; and" and

(4) by adding at the end of paragraph (15) (as redesignated by paragraph (2) of this subsection) the following new sentence: "Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this subsection to be filed with the Secretary shall be made available to Federal or State employees for purposes consistent with the effective administration of programs established under titles XVIII and XIX of this Act."

42 USC 1395, 1396.

(c) The amendments made by this section shall be effective July 1, 1973. Effective date.

LEVEL OF CARE REQUIREMENTS FOR SKILLED NURSING HOME SERVICES

SEC. 247. (a) Section 1814(a)(2)(C) of the Social Security Act is amended by striking out everything which appears before "(or services" and inserting in lieu thereof the following: 42 USC 1395f.

"(C) in the case of post hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services".

(b) Section 1905 of the Social Security Act, as amended by section 212 of this Act, is further amended by adding at the end thereof the following new subsection: Ante, p. 1384.

"(f) For purposes of this title, the term 'skilled nursing facility services' means services which are or were required to be given an individual who needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis." "Skilled nursing facility services."

(c) The amendments made by this section shall be effective with respect to services furnished after December 31, 1972. Effective date.

MODIFICATION OF MEDICARE'S 14-DAY TRANSFER REQUIREMENT FOR EXTENDED CARE BENEFITS

SEC. 248. Section 1861(i) of the Social Security Act is amended by striking out "within 14 days after discharge from such hospital:" and inserting in lieu thereof the following: "(A) within 14 days 42 USC 1395x.

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Appendix "A"

approved by the Secretary as a provider of services. Such approvals will be granted only when there are no deficiencies of such character and seriousness as to place health and safety of individuals in jeopardy. A hospital receiving this special approval shall furnish information showing the extent to which it is making the best use of its resources to improve its quality of care.

(b) *Minimum compliance requirements.* Each case will have to be decided on its individual merits, and while the degree and extent of compliance will vary, the institution must, as a minimum, meet all of the statutory conditions in section 1861(e)(1)–(8), in addition to meeting such other requirements as the Secretary finds necessary under section 1861(e)(9). (For further information relating to the exception in section 1861(e)(5) of the Act, see paragraph (c) of this section.)

(c) *Waiver of 24-hour registered nurse requirement.* For a period ending January 1, 1976, the Secretary is authorized to waive the requirement contained in section 1861(e)(5) that a hospital must provide 24-hour nursing service rendered or supervised by a registered nurse. Such a waiver may be granted for any 1-year period upon acceptance by the Secretary of findings adequately documented and certified by the State agency, that the following criteria are met:

(1) The hospital complies with all other requirements for special certification provided in this section.

(2) At least one registered nurse is employed full-time and sufficient other registered nurses are employed to assure that the day tour of duty is covered by a registered nurse 7 days a week.

(3) The hospital has in charge, on all tours of duty not covered by a registered nurse, a licensed practical (vocational) nurse who is a graduate of a State-approved school of practical (vocational) nursing or one who has passed a proficiency examination when such examinations are available and approved by the Secretary. Until such time as this examination is available, waivered licensed practical (vocational) nurses may serve as charge nurses.

(4) The hospital is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein and the failure to qualify as a participating hospital would seriously reduce the availability of such services to such individuals.

(5) The hospital has made and continues to make a good faith effort to comply with section 1861(e)(5), but such compliance is impeded by the lack of qualified nursing personnel in such area.

[FR Doc.74-1323 Filed 1-16-74;8:45 am]

Title 45—Public Welfare

CHAPTER II—SOCIAL AND REHABILITATION SERVICE (ASSISTANCE PROGRAMS), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

MEDICAL ASSISTANCE PROGRAM

Notice of proposed rulemaking to implement sections 239, 246 and 249A of Pub. L. 92-603 relating to the medical assistance program under title XIX of the Social Security Act, was published on July 12, 1973 in the FEDERAL REGISTER (38 FR 18616).

Interested parties were given the opportunity to submit comments on the proposed amendments within 30 days. The comment period was extended by the Secretary for an additional 30 days to September 13, 1973, and notice of this extension appeared in the FEDERAL REGISTER of August 14, 1973.

The comments received concerning Subpart K—Conditions of Participation; Skilled Nursing Facilities (38 FR 18621) as they apply to skilled nursing facilities under the Medicaid program were jointly reviewed with the Social Security Administration. The changes adopted will be reflected in the final regulations issued by the Social Security Administration in 20 CFR 405.1101 and 405.1120 through 405.1137.

The comments received concerning the Medicaid provisions under 45 CFR Parts 205, 249 and 250 reflected general and overall approval of the regulations as proposed. Some concern was expressed with respect to uniformity in skilled nursing facility certification language for both Medicaid and Medicare. The regulations have been amended to adopt insofar as possible identical certification language for both programs.

In addition, Medicaid provisions under 45 CFR Part 249 have been revised to delete existing Federal requirements under the definition of skilled nursing home services and the certification procedures for skilled nursing facilities have been reorganized with no significant changes to clarify the roles and responsibilities of the State survey agency and the title XIX agency in the certification of skilled nursing facilities and intermediate care facilities under the Medicaid program. The Medicaid provisions under 45 CFR Part 249 applicable to intermediate care facilities have also been modified to include a provision requiring that institutions for the mentally retarded submit a plan for achieving compliance with standards in § 249.13 which become effective three years from the effective date of the standards issued for intermediate care facilities under the Medicaid program.

PART 205—GENERAL ADMINISTRATION—PUBLIC ASSISTANCE PROGRAMS

Chapter II, Title 45, Code of Federal Regulations is amended as set forth below.

1. Section 205.190 is amended by revising the introductory words to paragraph (a) to read as set forth below, and by deleting the reference to medical assistance in paragraph (a)(2)(i), and the last sentence of paragraph (a)(2), and by revising paragraph (a)(2)(iii) (g) and (h):

§ 205.190 Standard-setting authority for institutions.

(a) *State plan requirements.* If a State plan under title I, X, XIV, or XVI of the Social Security Act includes aid or assistance to individuals in institutions as defined in § 233.60(b) (1) and (2) of this chapter, the plan must:

(1) Provide for the designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

(2) Provide that the State agency will keep on file and make available to the Social and Rehabilitation Service upon request:

(i) A listing of the types or kinds of institutions in which an individual may receive financial assistance:

(ii) A record naming the State authority(ies) responsible for establishing and maintaining standards for such types of institutions;

(iii) The standards to be utilized by such State authority(ies) for approval or licensing of institutions including, to the extent applicable, standards related to the following factors:

(*a*) Health (dietary standards and accident prevention);

(*b*) Humane treatment;

(*c*) Sanitation;

(*d*) Types of construction;

(*e*) Physical facilities, including space and accommodations per person;

(*f*) Fire and safety;

(*g*) Staffing, in number and qualifications, related to the purposes and scope of services of the institution;

(*h*) Resident records;

(*i*) Admission procedures;

(*j*) Administrative and fiscal records;

(*k*) The control by the individual, or his guardian or protective payee, of the individual's personal affairs.

• • • • •

PART 249—SERVICES AND PAYMENT IN MEDICAL ASSISTANCE PROGRAMS

2. Section 249.33 is revised to read as follows:

§ 249.33 Standards for payment for skilled nursing facility and intermediate care facility services.

(a) *State plan requirements.* A State plan for medical assistance under title XIX of the Social Security Act must:

(1) Provide that the single State agency will, prior to execution of an agreement with any facility (including hospitals) for provision of skilled nursing facility services and making payments

Appendix "B"

under the plan obtain certification from:

(i) The agency designated pursuant to § 250.100(c) of this chapter that the facility meets the statutory definition contained in section 1861(j) of the Social Security Act and is in full compliance with the standards prescribed by the Secretary in the regulations promulgated thereunder, except that for purposes of § 405.1134(c) of this title, the agency may waive, or, for purposes of § 405.1134(e) of this title, the agency may permit, variations in the provisions therein for facilities participating only under title XIX, provided such waiver or variation is authorized under conditions promulgated by the Secretary; or

(ii) The Secretary, pursuant to section 1910 of the Act, that the facility has been determined to qualify as a skilled nursing facility under title XVIII of the Act; or

(iii) The Secretary, pursuant to section 1905 of the Act, in the case of a facility located in the State on an Indian reservation that it meets the statutory definition contained in section 1861 (j) of the Social Security Act and in full compliance with the standards prescribed by the Secretary in the regulations promulgated thereunder.

(2) Provide that the single State agency will, prior to execution of an agreement with any facility (including hospitals and skilled nursing facilities) for provision of intermediate care facility services and making payments under the plan, obtain certification from the agency designated pursuant to § 250.100 (c) of this chapter that the facility meets the definition set forth under § 249.10(b)(15) (proposed); except that in the case of an intermediate care facility determined to have deficiencies under the requirements for environment and sanitation (§ 249.12(a)(6)) or of the Life Safety Code (§ 249.12(a)(5)) it may be recognized for certification as an intermediate care facility in accordance with subparagraph (4)(iii) of this paragraph for a period not exceeding 2 years following the date of such determination provided that:

(i) The institution submits a written plan of correction acceptable to the survey agency which contains:

(A) The specific steps that it will take to meet all such requirements; and

(B) A timetable not exceeding 2 years from the date of the initial certification after publication of these regulations detailing the corrective steps to be taken and when correction of deficiencies will be accomplished;

(ii) The survey agency makes a finding that the facility potentially can meet such requirements through the corrective steps and they can be completed during the 2 year allowable period of time;

(iii) During the period allowed for corrections, the institution is in compliance with existing State fire safety and sanitation codes and regulations;

(iv) The institution is surveyed by qualified personnel at least semiannually until corrections are completed and the survey agency finds on the basis of such surveys that the institution has in fact made substantial effort and progress in its plan of correction as evidenced by supporting documentation, signed contracts and/or work orders, and a written justification of such findings is maintained on file; and

(v) At the completion of the period allowed for corrections, the intermediate care facility is in full compliance with the Life Safety Code (NFPA, 21st Edition 1967), and the requirements for environment and sanitation set forth under § 249.12(a)(6), except for any provisions waived in accordance with § 249.12.

(3) Provide that any intermediate care facility receiving payments under the plan must supply to the licensing agency of the State full and complete information, and promptly report any changes which would affect the current accuracy of such information, as to the identity:

(i) Of each person having (directly or indirectly) an ownership interest of 10 percent or more in such facility,

(ii) In case a facility is organized as a corporation, of each officer and director of the corporation, and

(iii) In case a facility is organized as a partnership, of each partner;

(4) Provide that certification by the survey agency designated pursuant to § 250.100(c) of this chapter will be subject to the following provisions and exclusions:

(i) For purposes of paragraph (a)(1)(i) of this section, the facility is in compliance with each condition of participation as determined by the manner and degree to which the facility satisfies the standards within each condition;

(ii) For purposes of paragraphs (a)(1)(i) and (a)(2) of this section, the facility is in full compliance with the standards or meets the following conditions for any standards not fully met:

(A) The deficiencies noted, individually or in combination neither jeopardize the health and safety of patients nor are of such character as to seriously limit the provider's capacity to render adequate care. A written justification of such findings is maintained on file by the survey agency; and

(B) The facility provides in writing a plan of correction acceptable to the survey agency;

(iii) In the case of facilities certified under the provisions of paragraph (a)(4)(ii)(A) and (B) of this section certification will be for:

(A) A period that is no later than the 60th day following the end of the time period specified for the correction of deficiencies in a written plan which the survey agency has approved provided that such period shall not exceed 12 full calendar months or

(B) A conditional term of 12 full months, subject to an automatic cancellation clause that the certification will expire at the close of a predetermined date which no later than the 60th day following the end of the time period specified for the correction of deficiencies: *Provided*, That such date will occur within such 12-month period, unless the survey agency finds that all required corrections have been satisfactorily completed, or unless the survey agency finds and notifies the State agency that the facility has made substantial progress in correcting such deficiencies and has resubmitted in writing a new plan of correction acceptable to the survey agency. Except as provided in paragraph (a)(6) of this section, the period of a certification shall not exceed 12 calendar months.

(iv) No second certification under the condition specified in paragraph (a)(4)(ii) of this section may be executed if:

(A) The standard found deficient was in compliance during the previous certification period, except where the survey agency has made a determination based upon documented evidence that the facility despite intensive efforts or for reasons beyond its control was unable to maintain compliance and despite the deficiency(ies) the facility is making the best use of its resources to render adequate care; or

(B) The standards found deficient are the same as those which occasioned the prior certification, except:

(*1*) In a case where a facility can document to the State survey agency's satisfaction that it achieved compliance with a previously unmet standard during the period of certification but for reasons beyond its control and despite, in the judgment of the survey agency, a good faith effort to maintain compliance with the standard, was again out of compliance by the time of the next survey; or

(*2*) In the case of a skilled nursing facility completing the second of two successive agreements under provisions for certification in effect prior to July 1, 1973 and having the same deficiency(ies) which occasioned the two agreements, the survey agency will review the performance of such facility (which may be limited to a review of the documentation of record) in providing safe and adequate patient care and in progressing toward correction of such deficiency(ies). On the basis of its evaluation, the survey agency will advise the single State agency that:

(*i*) No provider agreement may be executed with such facility,

(*ii*) A new provider agreement may be executed for a period related to the time required to correct such deficiencies, but not to exceed six months; or

(*iii*) A new provider agreement may be executed for a period of twelve months but subject to a provision for automatic cancellation 60 days following the scheduled date for correction unless the survey agency finds and notifies the State agency that all required corrections have been satisfactorily completed. If the facility continues to be out of compliance with the same standard(s) at the end of the term of the agreement, a recertification may not be made.

(v) For purposes of this subparagraph (4), waivers granted pursuant to section 1902(a)(28) of the Act or § 249.12 are not considered deficiencies.

(5) Provide that the survey agency designated pursuant to § 250.100(c) of this chapter will:

(i) Review information contained in medical review and independent professional review team inspections made pursuant to State plan provisions under section 1902(a)(26) and (31) of the Social Security Act;

(ii) Review statements obtained from each facility setting forth (from payroll records) the average numbers and types of personnel (in full-time equivalents) on each shift during at least 1 week of each quarter, such week to be selected by the survey agency and to occur irregularly in each quarter of the year;

(iii) Review and evaluate such reports as they reflect on health and safety requirements and as necessary take appropriate action to achieve compliance or withdraw certification; and

(iv) Perform, with qualified personnel, on-site inspections at least once during the term of a certification or more frequently if there is a question of compliance.

(6) Provide that execution of the single State agency provider agreement with a facility for payments under the plan shall be contingent upon certification in accordance with the provisions of paragraph (a)(1) and (2) of this section. The term of an agreement may not exceed a period of one year and the effective date of such agreement may not be earlier than the date of certification. Execution of a provider agreement shall be for the term and in accordance with the provisions of certification determined by the survey agency except that the single State agency for good cause based on adequate and documented evidence may elect to execute a provider agreement for a term less than the full period of certification or may elect not to execute a provider agreement or may cancel a provider agreement for participation by a facility certified under the State plan. Notwithstanding the provisions of this subparagraph the single State agency may extend such term for a period not exceeding two months where the survey agency has notified the single State agency in writing prior to the expiration of a provider agreement that the health and safety of the patients will not be jeopardized thereby, and that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services or that it is impracticable within such provider agreement period to determine whether such facility is complying with the provisions and requirements under the program.

(7) Provide that in the case of a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions, the single State agency will, prior to the execution of an agreement for the provision of intermediate care facility services, obtain a written agreement from the State or political subdivision responsible for the operation of such public institution that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to

(i) Services furnished to residents in such institutions (or distinct part thereof) and (ii) services for individuals released during the preceding four quarters as provided in § 249.10(c)(3), will not, because of payments made under the plan, be reduced below the average quarterly per capita amount expended for services to residents in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its approved plan;

(8) Provide during the period ending three years after the effective date of section 249.13 that in the case of an institution (or distinct part thereof) for the mentally retarded or persons with related conditions, the single State agency will:

(i) Prior to the execution of a provider agreement covering intermediate care facility services, where the institution is not in compliance with the standards specified in § 249.13, obtain a written plan of compliance which shall be submitted (including any amendments thereto) by the institution to the single State agency and approved by the Secretary, for achieving conformity with the standards specified in § 249.13. The plan of compliance shall:

(A) Detail the extent of the institution's current compliance with the standards prescribed in § 249.13, and the specific action steps required to achieve compliance with the standards specified in such section, including:

(*1*) The number, job titles, and qualifications of personnel currently employed by the facility and arrangements for recruiting and training additionally required personnel sufficient to assure that each resident participates in an effective program of active treatment;

(*2*) Any necessary structural changes and renovations to buildings and a schedule for their completion;

(*3*) The programs and services currently provided and any required reorganization or expansion thereof.

(B) Establish a timetable not exceeding 3 years from the effective date of § 249.13 for completion of all action steps necessary to achieve conformity with the standards specified in § 249.13;

(C) In the case of a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions, provide for approval of the plan of compliance by the State or political subdivision having jurisdiction over the operation of such public institution;

(D) Provide for semi-annual reports to be submitted to the single State agency by the institution documenting the actions taken and recording the progress made in implementing the plan of compliance;

(ii) Prior to the execution of a second (and each and any succeeding) provider agreement, obtain a written report from the survey agency (based on an on-site inspection) establishing that the facility is adhering to the timetable for completion of all necessary action steps referred to in paragraph (a)(8)(i) of this section.

(9) Provide that in the case of skilled nursing facilities certified under the provisions of title XVIII of the Social Security Act, the term of a provider agreement shall be subject to the same terms and conditions and coterminous with the period of approval of eligibility specified by the Secretary pursuant to that title, and upon notification that an agreement with a facility under title XVIII of the Act has been terminated or cancelled, the single State agency will take appropriate action to terminate the facility's participation under the plan. A facility whose agreement has been cancelled or otherwise terminated may not be issued another agreement until the reasons which cause the cancellation or termination have been removed and reasonable assurance provided the survey agency that they will not recur.

(10) Provide that facilities which do not qualify under this section are not recognized as skilled nursing facilities or intermediate care facilities for purposes of payment under title XIX of the Act.

(b) *Federal financial participation.* (1) Federal financial participation is available at 75 percentum in expenditures of the single State agency for compensation (or training) of its skilled professional medical personnel and staff directly supporting such personnel, which are necessary to carry out these regulations.

(2) Federal financial participation at applicable rates is also available for the single State agency to enter into a written contract (under the supervision of the Medical Assistance Unit) with the survey agency designated pursuant to § 250.100(c) of this chapter as necessary to carry out its responsibilities under these regulations. Such Federal financial participation is available only for those expenditures of the survey agency which are not attributable to the overall cost of meeting responsibilities under State law and regulations for establishing and maintaining standards but which are necessary and proper for carrying out these regulations.

PART 250—ADMINISTRATION OF MEDICAL ASSISTANCE PROGRAMS

3. A new § 250.100 is added to Part 250 as set forth below:

§ 250.100 Establishment and maintenance of State and Federal standards.

State plan requirements. A State plan for medical assistance under title XIX of the Social Security Act must:

(a) Provide for the designation of the State health agency or other appropriate State medical agency (whichever is utilized by the Secretary for purposes of title XVIII of the Act as specified in the first sentence of section 1864(a) of the Act) as the State authority responsible for establishing and maintaining health standards for private or public